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Charlotte Keel MEDICAL PRACTICE

SOP Emergency conveyance to hospital

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Background

Patients presenting in person to the practice may be found to need hospital admission. They may either collapse whilst in our service or present with worsening symptoms of an existing illness or condition. We have experienced some scenarios where an ambulance has been requested but does not arrive until after our closing time. There is less clinical support available after closing time which poses a risk to the clinician and the patient. The service only has access to the building between 8am and 8pm, outside which the NHSPS caretaker is unavailable, and the building should be closed.

SWAST operational response times

SWAST will triage requests for ambulance response as follows:

	Target response time	Scenarios
Category 1	7.5 minutes (in practice can be 20-25 minutes)	Cardiac arrest or peri-arrest situations where there is a need for immediate intervention and/or resuscitation.
Category 2	18 minutes (in practice this can be 6+ hours)	Appropriate diagnosis examples include: • Unconscious (effective breathing); • Airway compromise / Severe breathing problems; • Obstetrics emergency; • Meningitis / Septicaemia; • Acute MI / Unstable Angina; • Aortic aneurysm (AAA); • CVA or cerebral bleed
Category 3	120 minutes (in practice this can be 12+hours)	Appropriate diagnosis examples: • Unstable limb fractures; • Burns (not major); • Severe abdominal pains.
Category 4	180 minutes	Appropriate diagnosis examples: • Stable pneumonia; • Cellulitis for IV antibiotics; • X-rays for acute minor injuries; • Urological cases (non-acute retention); • Palliative care admissions; • Stable clinical cases; • Musculoskeletal problems
Urgent transport for admission	1hr, 2hr or 4hr	

The following is an extract from SWAST Requesting Ambulance Transport – a guide for healthcare professionals 118799-swasft-hcprequestanambulance-booklet-v12.indd

"If your patient requires a life threatening or emergency response (e.g. cardiac/respiratory arrest, unconscious, MI, stroke, airway compromise, anaphylaxis, obstetrics emergency etc.) then you should call 999.

If your patient requires urgent treatment and assessment within four hours due to their medical condition and are not clinically safe to travel to hospital by their own means, then you should contact the SWASFT HCP Urgent Transport number for your region (BNSSG 0300 369 0097)"

Clinical assessment

When a decision for hospital admission is made, consideration should be given to the most appropriate mode of transport. It may be helpful for the clinician to calculate the NEWS2 score as this is useful to convey the severity of the patient's condition to SWAST. It is noted that NEWS2 has not been validated in primary care, but unpublished data suggest it may be a useful indicator of 30-day survival in acutely unwell patients. The RCGP have published this update: NEWS2 score for assessing patients at risk of deterioration

Chart 2: NEWS thresholds and triggers

NEW score	Clinical risk	Response
Aggregate score 0–4	Low	Ward-based response
Red score Score of 3 in any individual parameter	Low–medium	Urgent ward-based response*
Aggregate score 5–6	Medium	Key threshold for urgent response*
Aggregate score 7 or more	High	Urgent or emergency response**

* Response by a clinician or team with competence in the assessment and treatment of acutely ill patients and in recognising when the escalation of care to a critical care team is appropriate.
**The response team must also include staff with critical care skills, including airway management.

Recommendations

Situational awareness

1) Patients in need of hospital admission from the premises should be flagged to the duty manager and CAS GP/clinician promptly
2) Patients awaiting emergency ambulance after 4 pm should be discussed with the duty manager and senior clinician to review the clinical need and ensure appropriate disposition before the practice is closed at 6.30pm.
3) No clinician should be working alone in the building with a patient awaiting hospital admission.

4) An upgrade of call category should not be sought purely based on closing hours. This creates an onward delay for other patients in the community with no access to clinical support and places them at an unacceptable increased risk.

Choice of transport

1) Urgent transport is reserved for wheelchair/bed bound requiring hospital admission within 4 hours when there is no need for clinical intervention. These patients are unlikely to present on the premises of the practice.
2) Consider a taxi or relative vehicle to transport any patient presenting themselves to the practice and meeting criteria for category 3 or 4 scenarios.
3) Any patient meeting category 2 criteria who presents as stable within the context of their illness could also be encouraged to take a taxi/relative's transport particularly if ambulance waits are prolonged. We are near all our receiving hospitals.
4) In exceptional circumstances, payment for a taxi by The practice/Brisdoc may be authorised by the duty manager. https://www.radar-brisdoc.co.uk/knowledgebase/taxi-bookings/
5) Patients should not be sent to their home address to await Ambulance transport. They should be advised to travel directly to the booked hospital.
6) Patients are not to be conveyed in staff vehicles.

Tables

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Version Control

Date	Version	Author	Change Details
